		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045930

Facility Name: Tower Hill Healthcare Center

Address: 759 Kane St. (Number) South Elgin (City) 60177 (Zip Code)

County: Kane

Telephone Number: (847) 697-3310 **Fax #** (847) 697-3354

IDPA ID Number: 721525738001

Date of Initial License for Current Owners: 10/25/2002

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-4580
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	206	Skilled (SNF)	206	75,396	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	206	TOTALS	206	75,396	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	609	324	3,545	4,478	8
9	SNF/PED					9
10	ICF	28,847	9,098		37,945	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,456	9,422	3,545	42,423	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.27%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/2002

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/2002 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 3,545

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	246,172	14,501	8,618	269,291		269,291		269,291			1
2	Food Purchase		245,601		245,601		245,601	(8,629)	236,972			2
3	Housekeeping	127,325	93,032		220,357		220,357	(19,650)	200,707			3
4	Laundry	96,387	16,598		112,985		112,985		112,985			4
5	Heat and Other Utilities			146,841	146,841		146,841	2,554	149,395			5
6	Maintenance	39,152	76,514	13,111	128,777		128,777	725	129,502			6
7	Other (specify):*											7
8	**TOTAL General Services**	509,036	446,246	168,570	1,123,852		1,123,852	(25,000)	1,098,852			8
	B. Health Care and Programs											
9	Medical Director			19,000	19,000		19,000		19,000			9
10	Nursing and Medical Records	1,710,627	40,180	18,435	1,769,242		1,769,242	24,224	1,793,466			10
10a	Therapy			412,869	412,869		412,869		412,869			10a
11	Activities	115,241	9,878		125,119		125,119		125,119			11
12	Social Services	26,827			26,827		26,827		26,827			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,852,695	50,058	450,304	2,353,057		2,353,057	24,224	2,377,281			16
	C. General Administration											
17	Administrative	88,736		96,500	185,236		185,236	1,307	186,543			17
18	Directors Fees											18
19	Professional Services			42,770	42,770		42,770	18,138	60,908			19
20	Dues, Fees, Subscriptions & Promotions			17,691	17,691		17,691	(3,613)	14,078			20
21	Clerical & General Office Expenses	267,946		69,170	337,116		337,116	88,214	425,330			21
22	Employee Benefits & Payroll Taxes			363,272	363,272		363,272	1,052	364,324			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,143	4,143		4,143	107	4,250			24
25	Other Admin. Staff Transportation			10,549	10,549		10,549	365	10,914			25
26	Insurance-Prop.Liab.Malpractice			22,162	22,162		22,162	1,727	23,889			26
27	Other (specify):* Mgmt Alloc of Benefits							18,777	18,777			27
28	**TOTAL General Administration**	356,682		626,257	982,939		982,939	126,074	1,109,013			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,718,413	496,304	1,245,131	4,459,848		4,459,848	125,298	4,585,146			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Tower Hill Healthcare Center #0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			25,350	25,350		25,350	110,261	135,611			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			66,887	66,887		66,887	129,149	196,036			32
33	Real Estate Taxes			84,968	84,968		84,968	5,369	90,337			33
34	Rent-Facility & Grounds			360,000	360,000		360,000	(360,000)				34
35	Rent-Equipment & Vehicles			10,457	10,457		10,457	1,911	12,368			35
36	Other (specify):*											36
37	**TOTAL Ownership**			547,662	547,662		547,662	(113,310)	434,352			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		111,974		111,974		111,974		111,974			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,094	113,094		113,094		113,094			42
43	Other (specify):* Nonallowable Costs			45,756	45,756		45,756	(45,756)				43
44	**TOTAL Special Cost Centers**		111,974	158,850	270,824		270,824	(45,756)	225,068			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,718,413	608,278	1,951,643	5,278,334		5,278,334	(33,768)	5,244,566			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,829)	30		9
10	Interest and Other Investment Income	(64,237)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(175)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(6,938)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(25,655)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(26,838)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (127,672)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	93,904		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 93,904		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (33,768)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Tower Hill Healthcare Center
Provider #: 0045930
01/01/04 to 12/31/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Schedule V Reference
Disallow Lab Expense	(6,806)	43
Disallow X-ray Expense	(9,724)	43
Disallow out of period legal bills	(8,904)	19
Disallow Chamber of Commerce	(200)	20
Misc income offset	(354)	21
Disallow RT Tax	(850)	43
	(26,838)	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sheldon Wolfe	42.5	See Attached Schedule 6B		See Attached		
Jack Rajchenbach	42.5			Schedule 6B		
Rosemary Betz	10.00					
Moshe Herman	5.00					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	$	Kane Street Associates	100.00%	$ 109,216	$ 109,216	1
2	V	32	Amortization - Interest		Kane Street Associates	100.00%	191,780	191,780	2
3	V	34	Rent	360,000	Kane Street Associates	100.00%		(360,000)	3
4	V	43	RT Tax		Kane Street Associates	100.00%	850	850	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 360,000			$ 301,846	$ * (58,154)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

TowerHill Care Center
Provider # 0045930
12/31/2004

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes	City
In-State:	
Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis
Out-of-State:	
St. Elizabeth Healthcare Center	Florissant, MO

Other Related Business Entities		
S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

** Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	S.W. Management Co.	100.00%	$ 61	$ 61	15
16	V	3	Housekeeping		S.W. Management Co.	100.00%	117	117	16
17	V	5	Utilities		S.W. Management Co.	100.00%	2,554	2,554	17
18	V	6	Maintenance		S.W. Management Co.	100.00%	725	725	18
19	V	17	Administrative - Salaries	72,500	S.W. Management Co.	100.00%	73,807	1,307	19
20	V	19	Professional Services		S.W. Management Co.	100.00%	27,042	27,042	20
21	V	20	Dues, Fees, Subs & Promotions		S.W. Management Co.	100.00%	129	129	21
22	V	21	Clerical - Salaries		S.W. Management Co.	100.00%	80,983	80,983	22
23	V	21	Clerical & General Office Exp.		S.W. Management Co.	100.00%	7,585	7,585	23
24	V	24	Travel and Seminar		S.W. Management Co.	100.00%	107	107	24
25	V	25	Other Admin. Staff Transport.		S.W. Management Co.	100.00%	365	365	25
26	V	26	Insurance-Prop, Liab & Malp.		S.W. Management Co.	100.00%	1,727	1,727	26
27	V	27	Mgmt. Allocation of Benefits		S.W. Management Co.	100.00%	18,777	18,777	27
28	V	30	Depreciation		S.W. Management Co.	100.00%	4,874	4,874	28
29	V	32	Interest		S.W. Management Co.	100.00%	1,606	1,606	29
30	V	33	Real Estate Taxes		S.W. Management Co.	100.00%	5,369	5,369	30
31	V	35	Rent-Equipment & Vehicles		S.W. Management Co.	100.00%	1,911	1,911	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 72,500			$ 227,739	$ * 155,239	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$ 23,867	S & E Medical Supply Co.	100.00%	$ 16,229	$ (7,638)	15
16	V	3	Housekeeping	2,179	S & E Medical Supply Co.	100.00%	2,179		16
17	V	10	Medical Supplies	2,763	S & E Medical Supply Co.	100.00%	7,220	4,457	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 28,809			$ 25,628	$ * (3,181)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Sheldon Wolfe	President	Administrative	42.50	See Schedule 7A	4	10.00%	Salary	$ 73,807	L17,C7	1
2	Rosemary Betz	Adm. Consultant	Administrative	10.00	See Schedule 7B	8	13.79%	Facility Fees	24,000	L17, C3	2
3	Moshe Herman	CFO	Administrative	5.00	See Schedule 7C	5.7	14.25%	Salary	23,393	L21,C7	3
4											4
5											5
6											6
7			Note: All individuals work in excess of 40 hours.								7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 121,200		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

TowerHill Care Center
provider # 045930
12/31/2004
Sheldon Wolfe **Schedule 7A**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	3	$ 55,355		$ 55,355
Caseyville Nursing and Rehab	3	55,355		55,355
Franklin Grove Nursing Center	3	55,355		55,355
Kenwood Healthcare Center	12	221,421		221,421
Oregon Healthcare Center	3	55,355		55,355
Shabbona Healthcare Center	4	73,807		73,807
Tower Hill Healthcare Center	4	73,807		73,807
Virgil Calvert Nursing and Rehab	3	55,355		55,355
St. Elizabeth Healthcare Center	1	18,452		18,452
Other	4	73,807		73,807
	40	$ 738,071		$ 738,071

SEE ACCOUNTANTS' COMPILATION REPORT

Towerhill Care Center
Provider #0045930
12/31/2004
Rosemary Betz **Schedule 7B**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from Facility	Fees from Facility	Total Compensation
Tower Hill Healthcare Center	8		$ 24,000	$ 24,000
Other Illinois Home	50	140,000		140,000
	58	$ 140,000	$ 24,000	$ 164,000

SEE ACCOUNTANTS' COMPILATION REPORT

TowerHill Care Center
provider # 045930
12/31/2004
Moshe Herman **Schedule 7C**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	4.2	$ 17,237		$ 17,237
Caseyville Nursing and Rehab	4.2	17,237		17,237
Franklin Grove Nursing Center	3.4	13,954		13,954
Kenwood Healthcare Center	8.8	36,115		36,115
Oregon Healthcare Center	2.8	11,491		11,491
Shabbona Healthcare Center	2.5	10,260		10,260
Tower Hill Healthcare Center	5.7	23,393		23,393
Virgil Calvert Nursing and Rehab	4.2	17,237		17,237
St. Elizabeth Healthcare Center	4.2	17,237		17,237
Other	0	-		-
	40	$ 164,160		$ 164,160

SEE ACCOUNTANTS' COMPILATION REPORT

s

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.W. Management Co.
Street Address: 7434 N. Skokie Blvd.
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	527,040	9	$ 429	$	75,396	$ 61	1
2	3	Housekeeping	Bed Days Available	527,040	9	820		75,396	117	2
3	5	Utilities	Bed Days Available	527,040	9	17,851		75,396	2,554	3
4	6	Maintenance	Bed Days Available	527,040	9	5,071		75,396	725	4
5	19	Professional Services	Bed Days Available	527,040	9	189,030		75,396	27,042	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	527,040	9	900		75,396	129	6
7	21	Clerical - Salaries	Bed Days Available	527,040	9	566,095	566,095	75,396	80,983	7
8	21	Clerical & General Office Exp.	Bed Days Available	527,040	9	53,023		75,396	7,585	8
9	24	Travel and Seminar	Bed Days Available	527,040	9	750		75,396	107	9
10	25	Other Admin. Staff Transport.	Bed Days Available	527,040	9	2,548		75,396	365	10
11	26	Insurance-Prop, Liab & Malp.	Bed Days Available	527,040	9	12,072		75,396	1,727	11
12	27	Mgmt. Allocation of Benefits	Bed Days Available	527,040	9	131,259		75,396	18,777	12
13	32	Interest	Bed Days Available	527,040	9	11,228		75,396	1,606	13
14	33	Real Estate Taxes	Bed Days Available	527,040	9	37,528		75,396	5,369	14
15	35	Rent-Equipment & Vehicles	Bed Days Available	527,040	9	13,358		75,396	1,911	15
16										16
17	17	Administrative - Salaries	Avg. Hours Worked	40	9	738,071	738,071	4	73,807	17
18	21	Clerical - Salaries	Avg. Hours Worked	40	7	62,307	62,307	0	0	18
19										19
20	30	Depreciation	Direct Cost						4,874	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,842,340	$ 1,366,473		$ 227,739	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S & E Medical Supply Co.
Street Address: 3100 Commercial Avenue
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 982-9300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost			$	$		$ 16,229	1
2	3	Housekeeping	Direct Cost						2,179	2
3	10	Medical Supplies	Direct Cost						7,220	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 25,628	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	MB Financial Bank		X	Mortgage	$25,886.40	8/20/03	$	$ 4,073,977	8/20/08	0.0525	$ 180,785	1
2			X	N/P - Auto	$741.00	09/20/02	44,459	25,194	9/20/07	0.0600	2,745	2
3												3
4												4
5												5
	Working Capital											
6	Member Loans	X		Line of credit	Varies	12/15/02	1,000,000	800,000	04/26/05	0.0525	44,189	6
7	Member Loans	X		Working capital		11/15/02	400,000	386,720	Demand	0.0600	19,953	7
8												8
9	TOTAL Facility Related				$26,627.40		$ 1,444,459	$ 5,285,891			$ 247,672	9
	B. Non-Facility Related*											
10								Interest income offset			(95)	10
11								SW Mgmt allocation - Mortgage			1,606	11
12								Amortization of mortgage costs			10,995	12
13								Non-related interest			(64,142)	13
14	TOTAL Non-Facility Related						$	$			$ (51,636)	14
15	TOTALS (line 9+line14)						$ 1,444,459	$ 5,285,891			$ 196,036	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 112,028	1
	Management Co. allocation	5,369	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 96,996	2
3. Under or (over) accrual (line 2 minus line 1).		$ (9,663)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 100,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 90,337	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002	106,693	11
2003	96,996	12

2004 real estate tax accrual = 96,996 x 1.03 = 99,906

Use 100,000

SW Management allocation $5,369

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tower Hill Healthcare Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0045930

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE (847)-982-2300 FAX #: (847) 982-2304

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-34-228-012	Long-term care property	$ 96,996.00	$ 96,996.00
2.	10-28-412-049-0000	SW Management allocation	$ 38,970.00	$ 5,369.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 135,966.00	$ 102,365.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,038 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care		2000	$ 150,000	1
2					2
3	TOTALS			$ 150,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	206		2002		$ 4,259,594	$	39	$ 109,220	$ 109,220	$ 1,082,123	4
5											5
6	Mgmt Co		1995		61,919		39	1,769	1,769	17,081	6
7											7
8											8
	Improvement Type**										
9	Nursing Stations			2002	10,000		5	2,000	2,000	4,500	9
10	Carpet			2002	3,239		7	462	462	964	10
11	Time Recorder			2002	6,505		5	1,301	1,301	3,361	11
12	Fire Alarm System			2003	2,072		7	296	296	543	12
13	Recooling Tower Pump			2003	2,600		5	520	520	823	13
14	Hot Water Heater			2004	38,024	1,115	20	951	(164)	951	14
15	Alarm System			2004	24,807	679	20	620	(59)	620	15
16											16
17											17
18	Allocation of SW Management - Leasehold improvemen			1995	6,607		20	330	330	3,655	18
19	Allocation of SW Management - Leasehold improvemen			1996	1,154		20	58	58	494	19
20	Allocation of SW Management - Leasehold improvemen			1997	1,661		20	83	83	828	20
21	Allocation of SW Management - Leasehold improvemen			1998	1,144		20	57	57	386	21
22	Allocation of SW Management - Leasehold improvemen			1999	3,176		20	159	159	807	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,422,502	$ 1,794		$ 117,826	$ 116,032	$ 1,117,136	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 28,353	$ 17,639	$ 6,006	$ (11,633)	10	$ 12,819	71
72	Current Year Purchases	21,196	2,967	1,514	(1,453)	10	1,514	72
73	Fully Depreciated Assets	618,000					618,000	73
74	Allocation of SW Management	15,991		1,589	1,589	10	13,620	74
75	TOTALS	$ 683,540	$ 20,606	$ 9,109	$ (11,497)		$ 645,953	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident care	2002 Volvo	2002	$ 39,234	$ 2,950	$ 7,847	$ 4,897	5	$ 22,364	76
77	Allocation SW Management	2004 Cadillac	2004	8,292		829	829	5	829	77
78										78
79										79
80	TOTALS			$ 47,526	$ 2,950	$ 8,676	$ 5,726		$ 23,193	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,303,568	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 25,350	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 135,611	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 110,261	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,786,282	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 10,457 Description: Copiers
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20	SW Management allocation			1,911	20
21	TOTAL		$	$ 1,911	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A,C3	hrs	$	13,388	$ 192,394	$	13,388	$ 192,394	1
2	Licensed Speech and Language Development Therapist	L10A,C3	hrs		806	24,387		806	24,387	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,C3	hrs		13,948	183,697		13,948	183,697	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				111,974		111,974	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	28,142	$ 400,478	$ 111,974	28,142	$ 512,452	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,000	$ 1,000	1
2	Cash-Patient Deposits	25,400	25,400	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,117,372	1,117,372	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,159	21,159	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	54,126	54,126	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,219,057	$ 1,219,057	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		4,295,574	14
15	Leasehold Improvements, at Historical Cost	62,831	126,928	15
16	Equipment, at Historical Cost	116,251	731,066	16
17	Accumulated Depreciation (book methods)	(72,263)	(1,786,282)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Schedule 17A		36,627	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 106,819	$ 3,553,913	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,325,876	$ 4,772,970	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 152,453	$ 152,453	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,407	30,407	28
29	Short-Term Notes Payable	1,186,720	1,186,720	29
30	Accrued Salaries Payable	143,412	143,412	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,263	16,263	31
32	Accrued Real Estate Taxes(Sch.IX-B)	100,000	100,000	32
33	Accrued Interest Payable	4,000	4,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	275,374	206,038	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,908,629	$ 1,839,293	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	25,194	25,194	39
40	Mortgage Payable		4,073,977	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 25,194	$ 4,099,171	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,933,823	$ 5,938,464	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (607,947)	$ (1,165,494)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,325,876	$ 4,772,970	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Tower Hill Healthcare Center
Provider #:0045930
12/31/04

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	Operating	After Consolidation
Due from prior owners	40,182	40,182
Employee loans	3,673	3,673
Employee payroll Advance	1,715	1,715
Reimbursement due/bad debt	5,337	5,337
Prepaid Expenses	2,745	2,745
Due to Public Aid	474	474
Total Line 9 - Other Current Assets (specify):	**54,126**	**54,126**

Other Current Liabilities (specify):	Operating	After Consolidation
Loan Costs	0	51,107
A/A Loan costs	0	(14,480)
Total Line 23 - Other (specify):	**0**	**36,627**

Other Long-Term Liabilities (specify):	Operating	After Consolidation
Insurance Premiums Payable	1,496	1,496
Due to state	12,494	12,494
Credit union	475	475
Union dues	2,884	2,884
Accrued Expenses	163,662	163,662
Accrued Management fees	2,000	2,000
Due / from Kane St. Assoc.	92,363	0
Due to Partners	.	23,027
Total Line 43 - Other Long-Term Liabilities (specify):	**275,374**	**206,038**

See Accountants' Compilation Report

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (580,658)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (580,658)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(27,289)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (27,289)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (607,947)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,869,143	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,869,143	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	370,436	6
7	Oxygen	11,017	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 381,453	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	95	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 95	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	354	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 354	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,251,045	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,123,852	31
32	Health Care	2,353,057	32
33	General Administration	982,939	33
	B. Capital Expense		
34	Ownership	547,662	34
	C. Ancillary Expense		
35	Special Cost Centers	157,730	35
36	Provider Participation Fee	113,094	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,278,334	40
41	**Income before Income Taxes (line 30 minus line 40)****	(27,289)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (27,289)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
This entity is a cash basis taxpayer

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 59,475	$ 28.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,642	26,223	683,114	26.05	3
4	Licensed Practical Nurses	8,435	8,938	194,327	21.74	4
5	Nurse Aides & Orderlies	61,561	65,167	773,711	11.87	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,840	9,995	115,241	11.53	10
11	Social Service Workers	1,741	1,747	26,827	15.36	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	43,589	20.96	13
14	Head Cook	6,191	6,882	70,916	10.30	14
15	Cook Helpers/Assistants	16,147	17,086	131,667	7.71	15
16	Dishwashers					16
17	Maintenance Workers	2,146	2,435	39,152	16.08	17
18	Housekeepers	15,191	16,620	127,325	7.66	18
19	Laundry	10,903	11,908	96,387	8.09	19
20	Administrator	2,000	2,080	88,736	42.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,146	17,022	267,946	15.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,943	190,263	$ 2,718,413 *	$ 14.29	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 8,618	L1, C3	35
36	Medical Director	192	19,000	L9, C3	36
37	Medical Records Consultant	96	4,309	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	14,126	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	96	12,391	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	576	$ 58,444		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeremy Amster	Administrator	0	$ 88,736
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,736

B. Administrative - Other

Description	Amount
Rose Betz - Management Fees	$ 24,000
SW Management - Home Office	72,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 96,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners Inc.	Unemployment Consultant	$ 766
Frost, Ruttenberg & Rothblatt	Accounting	13,641
Winston & Strawn	Legal	13,058
Ashman & Stein	Legal	12,969
Allen A Lefkovitz & Assoc	Legal	2,336
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 42,770

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,527
Unemployment Compensation Insurance	45,619
FICA Taxes	207,905
Employee Health Insurance	30,554
Employee Meals	1,052
Illinois Municipal Retirement Fund (IMRF)*	
Misc employee benefits	5,538
Life Insurance	4,539
Uniforms	3,590
TOTAL (agree to Schedule V, line 22, col.8)	$ 364,324

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,130
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 50)	700
Inspections	801
Permits	150
Dues and Subscriptions	1,564
IL Council on Long Term Care	7,026
Licenses	578
SW Management Allocation	129
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,078

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,143
SW Management Allocation	107
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,250

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Tower Hill Healthcare Center
Provider #: 0045930
12/31/2004

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	42,770
Out-of-period legal expenses	(8,904)
Allocated From SW Management:	
Accouning - Frost, Ruttenberg and Rothblatt	26,070
Legal	972
Total (agree to Schedule V, line 19, column 8)	60,908

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5			N/A										
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center **#** 0045930 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care-$7,026**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **19,767** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **113,094**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **1,052** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

		Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary		246,172	14,501	8,618	269,291	0	269,291	0	269,291
2. Food Purchase		0	245,601	0	245,601	0	245,601	-8,629	236,972
3. Housekeeping		127,325	93,032	0	220,357	0	220,357	-19,650	200,707
4. Laundry		96,387	16,598	0	112,985	0	112,985	0	112,985
5. Heat and Other Utilities		0	0	146,841	146,841	0	146,841	2,554	149,395
6. Maintenance		39,152	76,514	13,111	128,777	0	128,777	725	129,502
7. Other (specify)*		0	0	0	0	0	0	0	0
8. Total General Services		509,036	446,246	168,570	1,123,852	0	1,123,852	-25,000	1,098,852
9. Medical Director		0	0	19,000	19,000	0	19,000	0	19,000
10. Nursing & Medical Records		1,710,627	40,180	18,435	1,769,242	0	1,769,242	24,224	1,793,466
10a. Therapy		0	0	412,869	412,869	0	412,869	0	412,869
11. Activities		115,241	9,878	0	125,119	0	125,119	0	125,119
12. Social Services		26,827	0	0	26,827	0	26,827	0	26,827
13. Nurse Aide Training		0	0	0	0	0	0	0	0
14. Program Transportation		0	0	0	0	0	0	0	0
15. Other (specify)*		0	0	0	0	0	0	0	0
16. Total Health Care & Programs		1,852,695	50,058	450,304	2,353,057	0	2,353,057	24,224	2,377,281
17. Administrative		88,736	0	96,500	185,236	0	185,236	1,307	186,543
18. Directors Fees		0	0	0	0	0	0	0	0
19. Professional Services		0	0	42,770	42,770	0	42,770	18,138	60,908
20. Fees, Subscriptions & Promotion		0	0	17,691	17,691	0	17,691	-3,613	14,078
21. Clerical & General Office		267,946	0	69,170	337,116	0	337,116	88,214	425,330
22. Employee Benefits & Payroll		0	0	363,272	363,272	0	363,272	1,052	364,324
23. Inservice Training & Education		0	0	0	0	0	0	0	0
24. Travel and Seminar		0	0	4,143	4,143	0	4,143	107	4,250
25. Other Admin. Staff Trans		0	0	10,549	10,549	0	10,549	365	10,914
26. Insurance-Prop.Liab.Malpractice		0	0	22,162	22,162	0	22,162	1,727	23,889
27. Other (specify)*		0	0	0	0	0	0	18,777	18,777
28. Total General Adminis		356,682	0	626,257	982,939	0	982,939	126,074	1,109,013
29. Total General Administrative		2,718,413	496,304	1,245,131	4,459,848	0	4,459,848	125,298	4,585,146
30. Depreciation		0	0	25,350	25,350	0	25,350	110,261	135,611
31. Amortization of Pre-Op. & Org.		0	0	0	0	0	0	0	0
32. Interest		0	0	66,887	66,887	0	66,887	129,149	196,036
33. Real Estate		0	0	84,968	84,968	0	84,968	5,369	90,337
34. Rent - Facility & Grounds		0	0	360,000	360,000	0	360,000	-360,000	0
35. Rent - Equipment & Vehicles		0	0	10,457	10,457	0	10,457	1,911	12,368
36. Other (specify):*		0	0	0	0	0	0	0	0
37. Total Ownership		0	0	547,662	547,662	0	547,662	-113,310	434,352
38. Medically Necessary T		0	0	0	0	0	0	0	0
39. Ancillary Service Cent		0	111,974	0	111,974	0	111,974	0	111,974
40. Barber and Beauty Shop		0	0	0	0	0	0	0	0
41. Coffee and Gift Shops		0	0	0	0	0	0	0	0
	42	0	0	113,094	113,094	0	113,094	0	113,094
43. Other (specify):*		0	0	45,756	45,756	0	45,756	-45,756	0
44. Total Special Cost Ce		0	111,974	158,850	270,824	0	270,824	-45,756	225,068
45. Grand Total		2,718,413	608,278	1,951,643	5,278,334	0	5,278,334	-33,768	5,244,566

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,000	1,000
2. Cash - Patient Deposits	25,400	25,400
3. Accounts & Notes Recievable	1,117,372	1,117,372
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	21,159	21,159
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	54,126	54,126
10. Total current assets	1,219,057	1,219,057
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	150,000
14. Buildings, at Historical Cost	0	4,295,574
15. Leasehold Improvements, Historical Cost	62,831	126,928
16. Equipment, at Historical Cost	116,251	731,066
17. Accumulated Depreciation (book methods)	-72,263	-1,786,282
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	36,627
24. Total Long-Term Assets	106,819	3,553,913
25. Total Assets	1,325,876	4,772,970
CURRENT LIABILITIES		
26. Accounts Payable	152,453	152,453
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	30,407	30,407
29. Short-Term Notes Payable	1,186,720	1,186,720
30. Accrued Salaries Payable	143,412	143,412
31. Accrued Taxes Payable	16,263	16,263
32. Accrued Real Estate Taxes	100,000	100,000
33. Accrued Interest Payable	4,000	4,000
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	275,375	206,038
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,908,630	1,839,293
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	4,073,977
40.Mortgage Payable	25,194	25,194
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	25,194	4,099,171
46.Total Liabilities	1,933,824	5,938,464
47.Total Equity	-607,948	-1,165,494
48.Total Liabilities and Equity	1,325,876	4,772,970

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	4,869,143
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	4,869,143
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	370,436
7. Oxygen	11,017
Subtotal - Anciliary Revenue	381,453
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	0
25. Interest and Other Investments Income	95
Subtotal - Non-Operating Revenue	95
27. Other Revenue (specify):	354
28. Other Revenue (specify):	0
Subtotal - Other Revenue	354
30. Total Revenue	5,251,045
31. General Services	680,120
32. Health Care	1,154,988
33. General Administration	668,561
34. Ownership	144,710
35. Special Cost Centers	60,174
35. Provider Participation Fee	41,063
37. Other	0
40. Total Expenses	2,749,616
41. Income Before Income Taxes	2,501,429
42. Income Taxes	0
43. Net Income or Loss for the Year	2,501,429